rated relaxation into his daily activities and experienced a dramatic decrease in his pervasive anxiety. Three patients used relaxation to control previously intolerable situational anxiety. Six of the anxious patients had severe insomnia. Five of them learned to relax themselves to sleep, but often awoke during the night. However, they could relax back to sleep and were no longer reliant on the sedatives they had used for years. Four of the patients who had accompanying tension headaches reported pronounced improvement in this symptom.

Currently, other biofeedback techniques are being explored for their possible effectiveness in alleviating chronic anxiety. For example, patients are being trained to control both muscle tension and heart rate. Moreover, feedback-induced muscle relaxation has allowed patients, who had previously been too anxious to relax, to benefit from desensitization procedures.

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REFERENCES

Raskin M, Johnson G, Rondesvtedt JW: Chronic anxiety treated by feedback-induced muscle relaxation. Arch Gen Psychiatry 28:263-267, Feb 1973

Stoyva J, Budzynski T: Cultivated low arousal—An antistress response, *In* DiCara LV (Ed): Recent Advances in Limbic and Autonomic Research, New York City, Plenum, 1973

The Dying Child

RECENT STUDIES have shown that the child over four or five years of age who has a terminal illness does realize its seriousness and probably fatal outcome even when told otherwise. The maturity of a child's concept of death is related to his emotional and cognitive stage of development. Although the younger child may have an immature concept of death, the very thought is often associated with anxiety. Such children tend to think of death in terms of aggression or of separation or a combination of the two, either of which may be a source of anxiety. In supportive care of the dying child, honesty and truthfulness are important from those who work with him. Communication should be open so that the child feels free to voice his feelings of sadness, fear, helplessness, loss and anxiety. Parents and professionals must maintain the patient in realistic hope through conveying to the child that he will not be isolated physically or emotionally, that those upon whom he depends will not desert him, that there will be relief from pain, and that there is excellence in medical care.

Those involved in care of the dying child are inevitably involved in care of the dying child's family during the course of the illness and afterward. Each family member's reaction to terminal illness and subsequent loss is not only intrapsychic but inevitably interrelated with altered family dynamics. Each experiences a profound crisis with persisting effects which all too frequently are pathological. In a report of a retrospective study within a pediatric hematology clinic of 20 families who had lost a child from acute leukemia, it was found that in half the families studied, one or more members ultimately required psychiatric care. Also, in more than half, one or more previously (seemingly) well-adjusted siblings showed altered behavior patterns that indicated considerable difficulty in coping. Although these symptoms generally became manifest during the course of the sibling's terminal illness, the more severe reactions followed the actual death of the sibling and persisted.

The implications of this for preventive mental health are significant. One cannot focus on care of the dying child without considering the entire family.

Such families often need support from professionals in coping with the emotional impact of a child who is dying so that they in turn can provide the necessary support to the dying child. Subsequently, during the trying months after the death, many families need help in carrying out grief work.

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REFERENCES

Binger CM, Ablin AR, Feurstein RC, et al: Childhood leukemia: Emotional impact on patient and family. N Engl J Med 280:414-416, Feb 20, 1969

Anthony EJ, Koupernik C (Eds): The Child in His Family: The Impact of Disease and Death, *In* Yearbook of the International Association of Child Psychiatrists and Allied Professions, Vol 2, New York, Wiley Interscience, 1973

Homicide Prevention

INJURIES DUE to physical assaults are increasing, and, despite improvements in the availability and effectiveness of emergency room medicine, deaths from homicide also are increasing. The California homicide rate rose from 4.5 per 100,000 population in 1960 to 7.6 in 1970. A majority of murders are committed by friends or relatives of the victim. One-fourth of all murders occur within the family.

Workers in emergency telephone counseling and crisis intervention services report that 5 to 10